MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03960

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Boulevard Heights Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Boulevard Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4912 - Dent St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rose-Marie Auth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24 1930

8. AGE: Years	Months	Days	If less than one day
15	10	1	..... hrs. ..... min.

9. Birthplace: D.C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Benedict Auth
13. Birthplace: Washington, D.C

MOTHER
14. Maiden name: Caroline Mary Dieth
15. Birthplace: Germany

16. Informant: Benedict Auth

Address: 4912 - Dent St. Blvd Hgts

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 29 46 (Month) (Day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: W. W. Chamberlain Co.

Address: 517-11th St. S.E.

19 April 26 19 46 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946, at 0 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to April 25 1946 and that I last saw h... alive on April 24 1946

	DURATION
Immediate cause of death: Uremia terminal	2 wks
Due to: Chronic nephritis	5 yrs.
Due to:	
Other conditions: Cardiac failure	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward Auchenbach M. D. or other

Address: 1007 - 2nd St. N.W. Date signed 4/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03961

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Huntsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 Months
Hospital, institution, or street address where death occurred:
74th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Huntsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 74th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irene Bailey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1944

8. AGE: Years	Months	Days	If less than one day
1	6	8	..... hrs. ..... min.

9. Birthplace Washington NC
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Benjamin Franklin Bailey
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Jamie Harris
15. Birthplace Washington NC

16. Informant Benjamin F. Bailey
Address Huntsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 13 1946 (month) (day) (year)
Cemetery or crematory Baptist
Location Bladensburg Md

18. Funeral director D. F. Gaskins Sons
Address Bladensburg, Md

19. 4/13 1946 Amanda Deems
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pneumonia	
Due to Bronchopneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy Medical Examiner
23. SIGNATURE Howard F. Bond M. D. or other
Address Huntsville Md Date signed 4-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03962

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1621 - I. Street S. E
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Carl Bass

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 5, 1944

8. AGE:	Years	Months	Days	If less than one day
	1	3	27	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: (Child)

11. Industry or business:

FATHER
12. Name: Ray Bass
13. Birthplace: S. Springs, Tennessee

MOTHER
14. Maiden name: Carolyn St.Clair
15. Birthplace: LaPlata, Maryland

16. Informant: Ray Bass, Father
Address: 1825 16th St. N. W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 1 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Prince George Co., Md.

18. Funeral director: J. Wm. Lee Son & Co.

Address: 300 4½ St., N.E., Wash., D.C

19. Apr. 1 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 1946, at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945, to Apr. 1, 1946 and that I last saw h... alive on Apr. 1, 1946

Immediate cause of death	DURATION
Miliary tuberculosis	3 da
Due to Tuberculous meningitis	3 da
Due to Primary infection Tbc -	5 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 4.1.46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03963

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos., 7 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2212 - Fairlawn Ave. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: MARGARET BECKETT

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hylan L. Beckett
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): March 3, 1888

8. AGE:	Years	Months	Days	If less than one day
	58	1	24	...hrs. ...min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Anthony Karnien
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth ?
15. Birthplace: Germany

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr. 27, 1946 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E.

19. Apr. 27 1946 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 Tue 1946 at 5 50/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 Tue 1945 to April 27 Tue 1946 and that I last saw h... alive on April 27 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3 yrs. 3 mos.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 4/27/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

03964

Reg. Diat. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forrestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1158 N. Columbus Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ★ ✓

3.(a) FULL NAME
George Ernest Benton, George Ernest

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Married

6.(b) Name of husband or wife: Florence E. Benton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12 December 1906

8. AGE: Years	Months	Days	If less than one day
39	4	5	hrs. min.

9. Birthplace: Gates County, North Carolina (Town, county, and state)
10. Usual occupation: U. S. Army
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Official Records
Address: Andrews Field, Washington 20, D. C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 17 1946 (month) (day) (year)
Cemetery or crematory: to Washington D. C.
Location:
18. Funeral director: Wastler Funeral Home
Address: 301 E. Capitol St. Wash. D.C.
19. 4-17- 1946 Thos F Griffith. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 April 1946, at 11:34 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Extensive third degree burns, multiple fractures and lacerations	
Due to: Aircraft Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 17 April '46
Where did injury occur? Prince Georges County (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Forestville Md Date signed: 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03965

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince County
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution? 2 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5801 Queens Chapel road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Bird

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna Catherine Bird
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 26th 1869.

8. AGE: Years	Months	Days	If less than one day
76	7	2	..... hrs. ..... min.

9. Birthplace: Wheeling West Va.
(Town, county, and state)
10. Usual occupation: Oil Driller (Retired.)
11. Industry or business

FATHER
12. Name: Roseburg Bird.
13. Birthplace: England.

MOTHER
14. Maiden name: Theresa Huth.
15. Birthplace: U. S. A.

16. Informant: Mrs Nellie B. Jeffrey
Address: 54 - Sargent Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland. Md.
18. Funeral director: W. W. Chambers Co.
Address: Riverdale, Md.

19. April 25 1946 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1946, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 16 1946 to April 24 1946 and that I last saw him alive on April 23 1946

Immediate cause of death	DURATION
Hypertensive heart disease with congestive failure —	
Due to: Hypertension	
Due to:	
Other conditions: arteriosclerosis, asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A. Simpson M. D. or other
Address: 101 E Monroe St. N.E. Date signed: April 24, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03966

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
5705 Baltimore ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5705 Baltimore ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rev. William Packer Blake.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Laura Longmeier
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 14 - 1857

8. AGE: Years: 88 | Months: 4 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Martinsburg, Pa.
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business:

FATHER
12. Name: James Blake
13. Birthplace: Pa.

MOTHER
14. Maiden name: Margaret Ellen Brown
15. Birthplace: Pa

16. Informant: Nelson W. Blake
Address: 5705 Baltimore Ave

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 4/11/46 (month) (day) (year)

Cemetery or crematory
Location: Wash. D.C. - Removal

18. Funeral director: S.T. Hines Co.
Address: 2401 14th St. N.W.

19. Apr 11 1946 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 19 43, to April 11 19 46
and that I last saw him alive on April 11 19 46

Immediate cause of death	DURATION
Cerebral Accident	
Due to Generalized Arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. Alert Lee M.D.
M. D. or other
Address: Hyattsville Md Date signed 4-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 0396 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bohannan Mrs. Jennie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	M

6.(b) Name of husband or wife: Bohannan, Mr. Joseph
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21 1910

8. AGE:

Years	Months	Days	If less than one day
36	2	11	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: H.W.

11. Industry or business

FATHER
12. Name: Geo. E. Weed
13. Birthplace —

MOTHER
14. Maiden name: Gertrude Riggles
15. Birthplace: Md.

16. Informant: Joseph B. Bohannon
Address: Lanham, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 4. 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C.

18. Funeral director: F Gabelia Sons
Address: Hyattsville Md

19. 4/1 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1946, to Apr. 1 1946 and that I last saw her alive on March 31 1946

Immediate cause of death: Cancer of both breasts with metastasis to liver and other internal organs. — DURATION: 14 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Charles C. Hagecage M.D. M.D. or other
Address: Mt. Rainier, Md. Date signed: Apr. 1, 1946

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56-2)

03968

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County ~~Montgomery~~ Prince Georges
City or town ~~Takoma Park~~
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
513 Ethan Allen.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Prince Georges
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513- Ethan Allen Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edson Carroll Bowen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

B.(b) Name of husband or wife Mary Lou Bowen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 29- 1921

8. AGE:

Years	Months	Days	If less than one day
24	3	27	..... hrs. ..... min.

9. Birthplace Takoma Park- Md.
(Town, county, and state)
10. Usual occupation Mechanical Draftsman.
11. Industry or business
FATHER 12. Name Wm. T. Bowen
13. Birthplace Fairburg- West Va.
MOTHER 14. Maiden name Naomi R- Carroll
15. Birthplace Waynesboro Pa.
16. Informant Mrs. L. Bowen
Address 513 Ethan Allen Ave-
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29-1946 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director J. Arthur Walters
Address 254 Carroll St Takoma Park
19. Apr 27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1946, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1946, to April 27 1946
and that I last saw him alive on April 27th 1946

Immediate cause of death	DURATION
Pulmonary Hemorrhage	15 hrs.
Due to Adenoma rt. bronchus	8 yrs.
Due to	
Other conditions Bronchiectasis Rt.	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John L. Brounsberger M.D.
M. D. or other
Address Takoma Park Date signed 4/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

03969

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Pr. George
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29
Hospital, Institution, or street address where death occurred:
6411 Ritchie Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Geos Co.
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6411 Ritchie Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Washington Brady

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of wife: Alma J. Brady
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 13 1865

8. AGE: Years: 80 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Upper Marlboro, Pr Geo Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Tobacco Farm

FATHER
12. Name: George W Brady
13. Birthplace: Pr Geo Co Maryland

MOTHER
14. Maiden name: Charlotte Beall
15. Birthplace: Maryland

16. Informant: Mrs Alma J. Brady
Address: 6411 Ritchie Rd S.E. Wash 19, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-13-46 (month) (day) (year)
Cemetery or crematory: Forestville Methodist
Location: Forestville, Md.
18. Funeral director: Ritchie Brothers
Address: Upper Marlboro Md

19. 4-12-46 (Date rec'd by registrar) Wilbur D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 19 46, at 9:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to April 10 19 46 and that I last saw him alive on April 10 19 46

Immediate cause of death	DURATION
Uremia	3 Weeks
Due to: Interstitial nephritis	3 Years
Due to: General arteriosclerosis	3 Years.
Other conditions: Senile myocarditis	3 Years.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Scott Ritchie M D
M. D. or other
Address: 6906 Ritchie Rd SE Washington 19, D.C. Date signed 10 Apr 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Thos. S. Collins.
324 H. St. N.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

03970 245
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County: Pr. Geo.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Sacred Heart Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: No County
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 600 Braddock Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Effie Virginia Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Geo. Brown
Dead 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1st 1866

8. AGE: Years	Months	Days	If less than one day
80	3	3	..... hrs. ..... min.

9. Birthplace: Alexandria Virginia.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: At home

FATHER
12. Name: Sanford Brown
13. Birthplace: Alexandria Va,

MOTHER
14. Maiden name: Rose Harner
15. Birthplace: Harpers Ferry W. Va.

16. Informant: Stewart K. Brown
Address: Alexandria Va.

17. Alexandria Va. (Burial, cremation, or removal. Which?) Date thereof 4-12-46 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Alexandria Virginia.

18. Funeral director: J.S. Everley
Address: Alexandria Va.

19. April 10 1946 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10th 1946 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1940, to April 10 1946 and that I last saw h... alive on April 9 1946

Immediate cause of death	DURATION
Bronchopneumonia	
Due to Cancer of Ear	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank S. Pellegrini M.D. or other
Address: 3409 Alabama Ave. S.E. Date signed 4/10/46

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (107) FX 03971

County Prince Georges Registration Dist. No. 240

Village or City Brandywine No. St., Ward

(If death occurred in a horpital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Rose Lee Brown

(a) Residence: No. Brandywine Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Col	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, dey, end year) Sep 10-1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	23 Days	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Freedmans Work Wash. D.C.

FATHER

13. NAME Edward Brown

14. BIRTHPLACE (city or town) (Stete or country) Waldorf Md

MOTHER

15. MAIDEN NAME Agnes Washington

16. BIRTHPLACE (city or town) (Stete or counlry) Upper Marlboro Md

17. INFORMANT Agnes L Brown (Address) Brandywine Md

18. BURIAL, CREMATIDN, OR REMDVAL Place Rosaryville Md Date 4/25, 1946

19. UNDERTAKER Edward Brown, Acting (Address) Croom, Md

20. FILED April 23, 1946 J H Billingsley Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 23 (Day) 46, 193 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 22, 1946, to April 23, 1946

I last saw her alive on April 23, 1946; death is said to have occurred on the dete stated above, at 2 P. m. 1:30 P.M

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Pneumonia Bronchial	Apr 18/46

Dther **Contributory Causes** of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HDME, or In PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Was diseese or injury in eny wey related to occupation of deceased? ...

If so, specify ...

(Signed) John E Bowers M. D.

(Address) Brandywine Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

03972

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forrestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7734 Emerson Road
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ★

3.(a) FULL NAME: Thomas J. Bukovac

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nelle C. Bukovac
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3 October 1921

8. AGE: Years	Months	Days	If less than one day
24	6	14	hrs. min.

9. Birthplace: Swiss Vale, Penna. (Town, county, and state)
10. Usual occupation: U. S. Army
11. Industry or business
FATHER 12. Name: A. J. Bukovac
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Official Records
Address: Andrews Field, Wash. 20, D. C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 17 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington D. C.
18. Funeral director: Wastler Funeral Home
Address: 301 E. Capitol St. Wash. D.C.
19. 4/17/46 19 (Date rec'd by registrar) Thos J. Suffolk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 April 19 46, at 11:34a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Extensive third degree burns, multiple fractures and lacerations	
Due to: Aircraft Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 17 April '46
Where did injury occur? Prince Georges County (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Forestville Md. Date signed: 4-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03973

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days.
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 M - Metzerott
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Burgie, Mary Leffler
3.(b) Social Security Number: —

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): — — 1870
8. AGE: Years 76 Months 4 Days 15 If less than one day ... hrs. ... min.
9. Birthplace: ? (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: unknown
13. Birthplace: "
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: hospital records
Address: Cheverly Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 17, 1946 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington D.C.
18. Funeral director: F. Gasch's sons
Address: Hyattsville Md
19. 4/17 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1946, at 6:10 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1946, to April 15 1946
and that I last saw her alive on April 15 1946

	DURATION
Immediate cause of death: Cardio Vascular disease.	10 years
Due to: Arteriosclerosis	10 years
Due to: Gangrene of Right foot & extremity	4 months
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Gangrene of right foot & extremity. Date of op. March 21, 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Saul Schwartzbach M.D. (M. D. or other)
Address: 1326 Eye St NW Date signed: April 16, 1946

VS-A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

03974

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3½ days

Hospital, institution, or street address where death occurred: Leland Memorial Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 625 - 4th St. S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Johnston Ludwell Cheseldine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1891

8. AGE:

Years	Months	Days	If less than one day
55	2	30	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: retired

FATHER 12. Name: Mr. Phillip Henry Cheseldine

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Felix Estelle Dudley

MOTHER 15. Birthplace: New Jersey

16. Informant: Mr. Phillip Mackey (nephew)

Address: 3214 5th St. S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof: April 10-46 (month) (day) (year)

Cemetery or crematory: St Barnabas Cemetery

Location: Oxon Hill, Maryland

18. Funeral director: Thomas F. Ryan

Address: 2007 - Nichols Ave S.E.

19. April 8 19 46 James Berry Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1946, at 12 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 46, to April 8 19 46

and that I last saw h. alive on April 3 19 46

Immediate cause of death: Intestinal Carcinoma of stomach

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry J. Hadley M.D. or other

Address: 1251 6th St. N.W. Date signed: April 8 46

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1760)

03975

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town College Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Route # 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina County

City or town Fort Bragg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Prcht. Inf.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clark, George

3.(b) Social Security Number Unk

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ethel Jesse Clark

6.(c) If alive, give age Unk years

7. Birth date of deceased (mo., day, yr.) 22 February 1926

8. AGE: Years	Months	Days	If less than one day
20	~~10~~ 1	~~13~~ 14	hrs. min.

9. Birthplace Brook (county unk) Indiana (Town, county, and state)

10. Usual occupation Soldier

11. Industry or business

FATHER

12. Name Clark, Faye W

13. Birthplace Lowell, Indiana

MOTHER

14. Maiden name Clark, Alice M

15. Birthplace Renssaler, Indiana

16. Informant

Address

17. Removal Date thereof 4-7-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ~~Geo. G. Greaple~~

KERR FUNERAL HOME

Location ~~Hawley, Md.~~ HARVEY, ILL.

18. Funeral director G. Gasch's Sons

ALSO: HOWARD BLIGHT

Address Hyattsville, Md. 4214 Belair Rd.

19. April 7 1946 James Sevey Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death Hemorrhage and Shock

Due to Fractured skull

Fracture of both femurs

Due to Crushed chest

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-6-46

Where did injury occur? College Park P.G. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury Passenger in Car in Collision Injured at work? Yes

Deputy medical Examiner

23. SIGNATURE James T. Ford M. D. or other

Address Forestville Md Date signed 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

03976

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: ~~Cheverly~~ Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)
Street No. 4302 Kaywood Dr. (If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Clark, Mrs. William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife: Grace Clark

7. Birth date of deceased (mo., day, yr.): April 28, 1873

8.(c) If alive, give age ..... years

8. AGE: Years: 13 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: N.Y. (Town, county, and state)
10. Usual occupation: Contractor (Retired)
11. Industry or business: own business

FATHER
12. Name: William Clark
13. Birthplace: N.Y.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown.

16. Informant: Mrs. Laurence Wade
Address: 4302 Kaywood Dr. Mt. Rainier

17. Disposition: Transportation (Burial, cremation, or removal. Which?) Date thereof: May 1. 1946 (month) (day) (year)
Cemetery or crematory: Greenfield Cemetery
Location: Hempstead New York

18. Funeral director: J. Gaschi & Son
Address: Hyattsville Md.

19. 5/1 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 30 1946 at 9 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 25 1946 to Apr 30 1946 and that I last saw him alive on Apr 30 1946

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Coronary arteriosclerotic Heart Disease with	
Due to: Heart Block, Left Bundle Branch type.	
Other conditions: Pneumonia, Bronchial Lower lobe, Rt. lung.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel J. Sugar M.D.
Address: 4300 Kaywood Drive, Mt. Rainier Md. M. D. or other
Date signed: 3 Apr 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03977

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale - RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 637-20'th, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MABLE Cook

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-1-1893

8. AGE: Years	Months	Days	If less than one day
52	8		hrs. min.

9. Birthplace: Athens, Georgis (Town, county, and state)

10. Usual occupation: domestic

11. Industry or business:

FATHER
12. Name: James Hardmon
13. Birthplace: not known

MOTHER
14. Maiden name: not known
15. Birthplace: not known

18. Informant: deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1946 (month) (day) (year)
Cemetery or crematory: Payne's Cemetery
Location: Washington, D.C.

18. Funeral director: Bruce Memorial Funeral Service
Address: 29 H St. NW, - D.C.

19. Apr 29 1946 (Date rec'd by registrar) Rowland S. Phelps Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 29 1946, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 9 1946 to APRIL 29 1946 and that I last saw h~~er~~ alive on APRIL 29 1946

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	1 mos +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 7/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MV 12

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170C)

03978

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bladensburg (If outside city or town limits, write RURAL and give nearest town)
Street No. 4314 Edmonston Road (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hermina Croggan
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife: William Croggan
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec 11, 1917
8. AGE: Years 28 Months 4 Days 6 If less than one day ____ hrs. ____ min.
9. Birthplace: Bladensburg Md (Town, county, and state)
10. Usual occupation: Lithographic Worker
11. Industry or business: Federal Lithograph Co
FATHER 12. Name: Herman Charles Wiencke
13. Birthplace: Germany
MOTHER 14. Maiden name: Minnie Ottilde Sachs
15. Birthplace: Washington DC
16. Informant: Hospital Records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 20. 1946 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Washington D.C.
18. Funeral director: F Gasch's sons
Address: Hyattsville Md.
April 20 1946 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1946, at 8:05 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Cerebral edema, Cerebral concussion	
Due to: Fracture of skull	
Due to:	
Other conditions: Collapsed left lung, Fracture pelvis (Include pregnancy within 3 months of death)	

Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4-7-46
Where did injury occur? Edmonston (City or town) P. G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury: Head on Collision with truck
Deputy medical Examiner
23. SIGNATURE: [illegible] M. D. or other
Address: Forestville Md Date signed 4-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 039 2143

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1623 - 33rd St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH HUBERT CULLINANE

3.(b) Social Security Number: 578-05-9736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 21, 1907

8. AGE:	Years	Months	Days	If less than one day
	38	5	18	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Olmstead Motor Co., Arlington, Va.

FATHER
12. Name: Cornelius Cullinane
13. Birthplace: Ireland

MOTHER
14. Maiden name: Delia Cloherty
15. Birthplace: Ireland

16. Informant: Decedent
Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4 - 9 - 46 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: WASH. D.C.

18. Funeral director: The B. H. Hines Co.

Address: 2901-14 St. N.W. Washington D.C.

19. APR. 8 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 8 1946, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 26 1946 to APRIL 8 1946 and that I last saw h.. alive on APRIL 8 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 wks.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 4/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03980

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Price George
City or town: Bladensburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
4621 Annapolis Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bladensburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4621 Annapolis Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Naomi L. D'Orsey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Robt. H.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 14 - 1884

8. AGE: Years	Months	Days	If less than one day
56			..... hrs. ..... min.

9. Birthplace: Salem Va (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Wm C Lynch
13. Birthplace: ~~Cora~~ Virginia

MOTHER
14. Maiden name: Cora H McDade
15. Birthplace: Savage Md

16. Informant: Robt H D'Orsey
Address: 4621 - Annapolis RD

17. Burial (Burial, cremation, or removal, which?) Date thereof May 1, 1946 (month) (day) (year)
Cemetery or crematory: Arlington Natl
Location: Virginia

18. Funeral director: R. E. H. Hines Co
Address: 2901 - 14th St NW

19. 4/29 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946, at 1 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 to April 29 1946
and that I last saw h.. alive on April 29 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Hypertension	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Isaac H Rountree M. D. or other
Address: 900 - 17th St NW Date signed: April 29 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

03981242
Reg. Diat. No.

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town TEMPLE HILLS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 YRS
Hospital, Institution, or street address where death occurred:
5093 TEMPLE ROAD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE
City or town TEMPLE HILLS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5093 - TEMPLE ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EDWARD FRANCIS DOWNS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife HAZEL DOWNS
6.(c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) NOV. 10, 1896

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace DIST. OF COLUMBIA (Town, county, and state)
10. Usual occupation BOILER MAKER
11. Industry or business

FATHER
12. Name EDWARD F. DOWNS
13. Birthplace MARYLAND

MOTHER
14. Maiden name FRANCIS GAFFENY
15. Birthplace MARYLAND

16. Informant MRS. HAZEL DOWNS
Address 5093 - TEMPLE HILL RD MD.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof Apr 9 46 (month) (day) (year)
Cemetery or crematory Arlington
Location Arlington Va
18. Funeral director W. W. CHAMBERS
Address 517 - 11th. ST S.E.
19. 4-6-19 46 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 46 at 4.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiosclerosis	
Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy medical Examiner
23. SIGNATURE ..... M. D. or other
Address ..... Date signed 4-6-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

★03982 242
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forrestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County:
City or town: Brookline
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1061 Beacon Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ★ ✓

3.(a) FULL NAME: Charles William Edgar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 14 April 1923

8. AGE: Years	Months	Days	If less than one day
23	-	3	hrs. min.

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: U. S. Army
11. Industry or business: Unknown
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Mrs. Alice L. Edgar
MOTHER 15. Birthplace: Unknown
16. Informant: Official Records
Address: Andrews Field, Wash. 20, D. C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof April 17 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington D. C.
18. Funeral director: Wastler Funeral Home
Address: 301 E. Capitol St. Wash D.C.
19. 4-17-1946 (Date rec'd by registrar) Thos. D. Griffith. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 April 1946, at 11:34 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Extensive third degree burns, multiple fractures and lacerations	
Due to: Aircraft Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 17 April '46
Where did injury occur? Prince Georges County (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Forestville Md. Date signed: 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03983

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEceased:
(For newborn infants give residence of mother)
State: Md. County: P.G.
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 497 - 61 st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Frami

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/22/1943

8. AGE:

Years	Months	Days	If less than one day
2	4	19	hrs. min.

9. Birthplace: Washington D.C (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Leo P. Frami
13. Birthplace: D.C

MOTHER
14. Maiden name: Ame Legana
15. Birthplace: Md

16. Informant: Leo. P. Frami
Address: 497 - 61st. St.

17. Burial (Burial, cremation, or removal—which?) Date thereof: Apr. 12, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
18. Funeral director: J. Wm. Lee's Sons Co
Address: 1350 - 4th NE. - Wash DC

19. April 14 1946 Irene Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1946 at 12 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1946, to April 11 1946
and that I last saw h-e alive on April 11 1946.

	DURATION
Immediate cause of death: Bronchopneumonia	8 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.
Address: Capitol Hgts, Md. Date signed: 4/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-04)

CERTIFICATE OF DEATH

★ 03984

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Geo. Co
City or town: East Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo. C
City or town: E. Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5406 Quintana St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles H. Gayle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1869

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business

FATHER 12. Name John Gayle
13. Birthplace Va

MOTHER 14. Maiden name Elizabeth Carder
15. Birthplace Va

16. Informant Girlie Bielight, niece
Address 5406 Quintana St. Riverdale md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-2-46 (month) (day) (year)

Cemetery or crematory Oakwood Cemetery
Location Richmond, Va

18. Funeral director WW Chambers Co
Address ~~Rt~~ Riverdale - md.

19. April 30 1946 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 6 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to Apr 30 1946
and that I last saw him alive on Apr 27 1946

Immediate cause of death: Cancer of larynx — DURATION: 3 Mo

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Truman Hays M. D. or other

Address: Hyatts - Md Date signed: 4/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 03985 243

Reg. Diat. No.

1. PLACE OF DEATH:
County: P. Geo.
City or town: near Bowie Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? nine time
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltemore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1910 Monford Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Abrahame Goldfarb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Dora
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
46			hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Clothing Cutter
11. Industry or business:
FATHER — 12. Name: unknown
13. Birthplace: Russia
MOTHER — 14. Maiden name: unknown
15. Birthplace: Russya
16. Informant: Dora Goldfarb.
Address: 1910 Monford Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-46 (month) (day) (year)
Cemetery or crematory:
Location: Hebrew Cemetery Balto
18. Funeral director: Jack Lewis Inc
Address: 7166 Eutaw Place Balto Md
19. April 13 1946 (Date rec'd by registrar) Mrs J. W. Quigley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1946 at 4.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1946, to April 13 1946 and that I last saw h him alive on April 12 1946

	DURATION
Immediate cause of death: Coronary Occlusion	1 hr.
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work? —

23. SIGNATURE: H E Lancaster md (M. D. or other)
Address: Bowie Md Date signed: Apr 13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mrs. John Youngberg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1942)

03986

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

511 - 64th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 - 2nd Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Edward Halfpop

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gloria Halfpop

6.(c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) June 11, 1917

8. AGE:

Years	Months	Days	If less than one day
33	10	8	...hrs. ...min.

9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business U.S. Govt

FATHER

12. Name Henry Hardwick Halfpop

13. Birthplace Bethesda, Md

MOTHER

14. Maiden name Margaret Grant

15. Birthplace Washington D.C.

16. Informant Mrs Gloria Halfpop

Address 511 - 64th St, Capitol Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1946 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director Wm Lee Sons Co

Address 308 4½ St SE Washington D.C.

19. April 19 1946 (Date rec'd by registrar) Irene Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946, at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Intra cranial hemorrhage	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md Date signed 4-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03987

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Clinton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Conn. County

City or town Woodmont
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Hillside Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Adelie Hardison

3.(b) Social Security Number 043-18-3332

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Jessie Bailey Hardison

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9 1869.

8. AGE: Years	Months	Days	If less than one day
76	5	6	...hrs. ...min.

9. Birthplace Washington No. Carolina
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Stainrite Paint Corp.

FATHER 12. Name John Robert Hardison

13. Birthplace N. Carolina

MOTHER 14. Maiden name Susan Clearcey

15. Birthplace No Carolina

16. Informant Katherine Thomas

Address Clinton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr 15 1946 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director W. W. Chambers Co.

Address 717-11th St. S.E.

19. 4-15-1946 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 15 1946 at 6 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1946 to Apr 15 1946 and that I last saw h... alive on April 14 1946

Immediate cause of death	DURATION
acute Coronary Thrombosis	20 Hours
Due to General Arteriosclerosis	unknown
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Washington 1906 Date signed Apr 15 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03988

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Mitchellville Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 66 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr George

City or town: Mitchellville Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Walker Farm Near Entrance 04

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Murray Harley

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Alexia Harley

6(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Nov 24, 1879

8. AGE:

Years	Months	Days	If less than one day
66	4	14	____ hrs. ____ min.

9. Birthplace: North Keys Prince Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: George Henry Harley

13. Birthplace: Charles Co. Md.

MOTHER

14. Maiden name: Susanna Newman

15. Birthplace: Charles Co. Md

16. Informant: Mary Alexia Harley

Address: 6876 Bock Rd. S.E. Wash. D.C.

17. buried (Burial, cremation, or removal. Which?) Date thereof: April 10, 1946 (month) (day) (year)

Cemetery or crematory: Holy family cemetery

Location: Mitchellville Md

18. Funeral director: Clarence Forecare

Address: Mitchellville Md

19. Apr. 9 1946 (Date rec'd by registrar) Louise H. Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1946, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946, to April 7 1946, and that I last saw h~~im~~ alive on April 7 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert S. McCreary M.D.

Address: 402 Main St Laurel Md M.D. or other

Date signed: 4/7/46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

03989

FILM No. I 04 MAY 10 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Chevery (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days.

Hospital, institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Chev. Mt. Ranier (If outside city or town limits, write RURAL and give nearest town)

Street No. 3401 - Newton St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Robert Horan.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	

6.(b) Name of husband or wife: Anna Horan.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30 - 1899

8. AGE: Years	Months	Days	If less than one day
46 56	10	24	hrs. min.

9. Birthplace (Town, county, and state): N.Y.

10. Usual occupation: Telegraphic clerk.

11. Industry or business:

FATHER — 12. Name: John Horan.

FATHER — 13. Birthplace: D.C.

MOTHER — 14. Maiden name: Mary Sullivan

MOTHER — 15. Birthplace: Ireland.

16. Informant: Mrs. Anna Horan.

Address: 3401 Newton St. Mt. Ranier.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: James T. Ryan.

Address: 317 - Rhode Is. A.E.

19. 4/26/1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15 1946, to 4-26 1946 and that I last saw h.. alive on 4-25 1946

Immediate cause of death: Coronary Occlusion 4-1-46 and again 4-25-46 — Duration: 26 days

Due to:

Due to:

Other conditions: 1. Aortic Stenosis — 20 years; 2. Carcinoma of Liver — 1 year

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Some

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Rogers M.D. M. D. or other

Address: Mt. Rainier Md. Date signed 4-26-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of sex & color is shown on FILM No. I 01 APR 29 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

*03990 Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Pr. Geo. Co.

City or town Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo. Co.

City or town Colmar Manor Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4302 Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna M. Horn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

8.(b) Name of husband or wife Edward Horn

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 20 1879

8. AGE: Years 66 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Dist of Columbia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Conrad Jost

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant Edward Horn

Address 4302 Monroe St. Colmar Manor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-22-46 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Wash. D.C.

18. Funeral director W.W. Chambers Co.

Address Riverdale Md.

19. 4/20 1946 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 18 1946, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1945, to Apr. 18 1946

and that I last saw h.. alive on Apr. 18 1946

Immediate cause of death	DURATION
Hypertensive Cardiac Failure	
Due to Hypertension	5 Yrs.
Due to	
Due to	
Other conditions Cardiac Asthma	9 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.H. Overton M. D. or other

Address 3827-34 Mt. Pleasant Date signed 4-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03991

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 - 5th St. N. W. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: RALPH C. JOBSON

3.(b) Social Security Number: 217-18-5992

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mabel Brown Jobson (dedeased)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 28, 1890

8. AGE:

Years	Months	Days	If less than one day
55	5	28	..... hrs. ..... min.

9. Birthplace: DuBois, Pennsylvania
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business:

FATHER
12. Name: William P. Jobson
13. Birthplace: DuBois, Pennsylvania

MOTHER
14. Maiden name: Jennie Chestnutt
15. Birthplace: DuBois, Pennsylvania

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 29 1946 (month) (day) (year)

Cemetery or crematory:

Location: To D.C. Morgue.

18. ~~Funeral director~~: John M. Stanley Assist Supt

Address: Glenn Dale San Glenn Dale Md.

19. Apr 25, 1946 Rowland S. Phelps
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 25, 1946, at 6:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 3, 1946 to Apr 25, 1946 and that I last saw him alive on Apr 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (992)

03992

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
4214 Queensbury Rd., Hyattsville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georg
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4214 Queensbury Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah E. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	married

6.(b) Name of husband or wife Harry Johnson
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 25, 1868

8. AGE: Years 77 | Months 8 | Days 28 | If less than one day ____ hrs. ____ min.

9. Birthplace Burlington, N. J.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Emerson Smith
13. Birthplace New Jersey

MOTHER
14. Maiden name Not obtainable
15. Birthplace New Jersey

16. Informant Emerson R. Johnson
Address 4214 Queensbury Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946
(month) (day) (year)

Cemetery or crematory
Location Camden N. J.
18. Funeral director D. Gasch's Sons
Address

19. April 23 1946 James Seery Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1946, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21, 1946, to April 23, 1946, and that I last saw her alive on April 23, 1946.

	DURATION
Immediate cause of death Congestive Heart Failure	3 days
Due to Hypertensive Vascular Disease	3 yrs.
Due to Generalized Arteriosclerosis	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE L. W. Malin M.D.
M. D. or other
Address Rendale Maryland Date signed 4/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03993

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 1 day

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2224 - 6th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: POMPEY JONES

3.(b) Social Security Number: 242-14-5-5963

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	Colored	M Married

6.(b) Name of husband or wife: Ruth Evelyn Jones

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): September 13, 1918

8. AGE: Years	Months	Days	If less than one day
27	7	6	..... hrs. ..... min.

9. Birthplace: Rocky Mt., North Carolina (Town, county, and state)

10. Usual occupation: Bakers' Helper

11. Industry or business:

FATHER — 12. Name: Pompey Jones

13. Birthplace: Rocky Mt., North Carolina

MOTHER — 14. Maiden name: Blummer Vaughan

15. Birthplace: Rocky Mt., North Carolina

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Apr. 19, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: W Ernest Jarvis Co.

Address: 1432 York St NW

19. Apr. 19 19 46 Rowland L. Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946, at 8:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/18 1946, to 4/19 1946

and that I last saw h.. alive on 4/19 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 4/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

03994

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George's
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4109 Queensbury Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thaddeus Douglas Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1943

8. AGE: Years 2 | Months 9 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Edward Clement Jones
13. Birthplace Montana

MOTHER 14. Maiden name Anna Viola Vadnais
15. Birthplace North Dakota

16. Informant Edward C. Jones
Address 4109 Queensbury Rd., Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 15 1946 (month) (day) (year)
Cemetery or crematory National Capital Park Cemetery
Location Muirkirk Md

19. Funeral director F Gaeche's sons
Address Hyattsville Md

18. Apr 15 1946 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Toxemia	
Due to Universal burns of the body and lower extremities	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4/11/46
Where did injury occur? Hyattsville (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home fire
Means of injury Clothes caught on fire from trash delivered at rock pile
Deputy Medical Examiner

23. SIGNATURE ..... M.D. or other
Address Hyattsville Md. Date signed 4-13-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03995

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: District Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 Ave E
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Donald Klein

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Sonia Klein
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 29 - 1908

8. AGE: Years: 37 | Months: 8 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Conn
(Town, county, and state)

10. Usual occupation: radio engineer

11. Industry or business

FATHER
12. Name: Herman Klein
13. Birthplace: Austria

MOTHER
14. Maiden name: Frances Frank
15. Birthplace: Conn

16. Informant: Mrs Sima Klein
Address: 609 Ave E District Heights

17. transportation (Burial, cremation, or removal. Which?) Date thereof: April 18, 1946 (month) (day) (year)

Cemetery or crematory: New York, N.Y.
Location

18. Funeral director: B Damansky & Son
Address: 3501-14th St, N.W.

19. April 18 1946 (Date rec'd by registrar) James Devoy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1946, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1946, to April 18 1946 and that I last saw h... alive on April 18 1946.

Immediate cause of death: Acute coronary thrombosis — DURATION: 15 hours

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Bruinin M. D. or Coroner

Address: Capitol Heights, Md. Date signed: 4/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

05395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George.
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 - 68th Place.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Warren Knight

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 18 - 1880

8. AGE: Years: 66. Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business: Hecht Co.

FATHER
12. Name: Louis J. Knight
13. Birthplace: D.C.

MOTHER
14. Maiden name: Emma M. Dority
15. Birthplace: Alexander Va.

16. Informant: Mrs. Emma M. Hotchkiss
Address: 505 - 68th R Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/17/46 (month) (day) (year)
Cemetery or crematory: MD. Olivet Cemetery
Location: Blandensburg Rd.

18. Funeral director: Albert Gasch
Address: 641 - H St N.E. Washington D.C.

19. April 13 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1946, at 10 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1946, to April 13 1946
and that I last saw h... alive on April 13 1946

	DURATION
Immediate cause of death: Cerebral embolism	
Heart disease with	
Congestive failure	2 months
Due to:	
Due to:	
Other conditions: Bronchopneumonia	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William Brainin M. D. or other
Address: Capitol Hgts, Md Date signed: 4/13/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03997

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 29 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 605 Eye St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sum Haw Lee

3.(b) Social Security Number: 579-26-5731

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Chinese	Married

6.(b) Name of husband or wife: Lew Lee

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): August 10, 1898

8. AGE:	Years	Months	Days	If less than one day
	47	8	2	...hrs. ...min.

9. Birthplace: China
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business:

FATHER — 12. Name: Fon Poo Lee
13. Birthplace: China

MOTHER — 14. Maiden name: Lims
15. Birthplace: China

16. Informant: Decedent
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16-1946 (month) (day) (year)

Cemetery or crematory: E. F. Lincoln

Location: Prince Georges Co. Md.

18. Funeral director: J. Wm. Leip Son's Co

Address: 300 - 4 st. N.E. - D.C.

19. Apr. 12 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1946, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14, 1945 to April 12, 1946 and that I last saw h... alive on April 12 1946.

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 1/2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 4/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of name & changed to married is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03998

FILM No. I 0 4 MAY 17 1946

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince George (WITHIN CORPORATE LIMITS OF)

City or town: Laurel - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dorothy ~~Smith~~ Leggett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	~~Single~~ Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9 1914

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
31.	8	27		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House work.

11. Industry or business

FATHER — 12. Name: Clarence E. Smith

13. Birthplace: Millsville Md

MOTHER — 14. Maiden name: Mollie Thomas

15. Birthplace: Anne Arundel Co. Md

16. Informant: Mrs. Clarence Smith

Address: 13 8th St Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April (month) 10 (day) 1946 (year)

Cemetery or crematory: Bacon

Location: Near Laurel, Md

18. Funeral director: Ridgley Selby

Address: 401 Washington Ave. Laurel Md

19. Apr 9 (Date rec'd by registrar) 19 46 M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 5 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 5 1946, to 4 5 1946

and that I last saw her alive on 4 5 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 D.
Due to: Chr. Nephritis	1 Yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Rubin M. D. or other

Address: Laurel Md Date signed: 4 8 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name of the deceased is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03999

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Pr. Geos.

City or town: Ritchie Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
6920 - Whitehouse Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo

City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6920 Whitehouse Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ada Mae Lusby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Christopher C. Lusby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29, 1887,

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace: Centreville Md.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: John Tucker.

FATHER — 13. Birthplace: Maryland.

MOTHER — 14. Maiden name: —

MOTHER — 15. Birthplace: —

16. Informant: Ada Mae Gaffney

Address: 3216-6th St. S. Arlington Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1946. (month) (day) (year)

Cemetery or crematory: Forestville Cemetery

Location: Forestville Md.

18. Funeral director: W. W. Chambers Co.,

Address: 517-11th St. Washington D.C.

19. 4-1-46 (Date rec'd by registrar) 19.....

Thos. D. Griffith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 31 1946 to April 1 1946

and that I last saw her alive on April 1 1946

	DURATION
Immediate cause of death: Coronary occlusion	24 hrs
Due to: General arterio sklerosis	3 Yrs History
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. Linton Ritchie M.D.
M. D. or other

Address: 6906 Ritchie Rd SE Wash 19, D.C. Date signed 1 Apr 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

04001

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George.
City or town: Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5117 - T St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Winfield. Scott. Maddox.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Married

6.(b) Name of husband or wife: Sadie Viola Maddox
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Pittsburgh Plate Glass
12. FATHER — Name: James Maddox
13. Birthplace: Md.
14. MOTHER — Maiden name: Matilda Fugit
15. Birthplace: Va
16. Informant: Marian Ray Bailey
Address: Avenue Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: W. W. Chambers Co.
Address: 517-11th St. S.E. Washington
19. 4-3- 1946 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to April 2 1946 and that I last saw h... alive on April 2 1946

Immediate cause of death	DURATION
Chronic myocarditis	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. C. Hartman M. D. or other
Address: 2215 Nichols St. Date signed 4-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. I 0 1 APR 29 1946

04002

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-C

CERTIFICATE OF DEATH

Reg. Dist. No. 2-34

1. PLACE OF DEATH:
County: Prince Georges
City or town: Allentown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Allentown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6301-Allentown Rd., S.E., Washington, D.C
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Viola Marshall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benjamin Marshall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 28th, 1898

8. AGE: Years	Months	Days	If less than one day
~~48~~ 47			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Lee Howard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Walton
15. Birthplace: Maryland

16. Informant: Benjamin Marshall
Address: 6301-Allentown Rd., S.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11, 1946 (month) (day) (year)
Cemetery or crematory: Washington Nat'l. Cemetery
Location: Suitland, Maryland

18. Funeral director: Thomas F. Murray
Address: 2007- Nichols Ave. S.E. Washington D.C.

19. April 9 — 1946 (Date rec'd by registrar) Howard I Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1946 at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Apr 9 1946 and that I last saw her alive on April 8 1946

Immediate cause of death	DURATION
Pulmonary edema	12 hrs
Due to: Carcinoma of Cervix with metastases	6 mo
Due to:	
Other conditions: Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul O'Leary Hatton M. D. or other
Address: Washington 12 D.C. Date signed: 4-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04003

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH
County: Pr. Geo. Co
City or town: Brentwood m.d.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md. County: Pr. Geo. Co
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3727 - R. I. ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: A. Elmer Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ruth E. Martin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 28 - 1883

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: Alexander Va (Town, county, and state)
10. Usual occupation: Train clerk
11. Industry or business: Wash. Terminal
FATHER 12. Name: Henry Clay Martin
13. Birthplace: Va
MOTHER 14. Maiden name: Ada Lightengale
15. Birthplace: Va
16. Informant: Ruth E. Martin
Address: 3727 R. I. Ave. Brentwood md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-11-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Wash. D.C.
18. Funeral director: Low Chamberg Co
Address: Riverdale md.
19. 4/10 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1946, at 405 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945 to April 7 1946
and that I last saw him alive on April 7 1946

Immediate cause of death	DURATION
Cancer of the throat	15 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hageage M.D. M. D. or other
Address: Mt. Rainier, md. Date signed: April 7, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V3 A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04004

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs., 4 mos.
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 yrs., 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2332 - 25th St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: MARTIN AMELIA

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: Eugene L. Martin
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Nov - 14 - 1880

8. AGE: Years	Months	Days	If less than one day
65	5	15	....hrs. ....min.

9. Birthplace: Loudon Co., Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Emery Daniels
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Gant
15. Birthplace: Virginia

18. Informant: Decedent
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Lanham Md.
18. Funeral director: W. W. Chambers Co.
Address: 517 - 11th St. S.E.

19. Apr 29, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 1946, at 12 30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/31 1940, to 4/29 1946, and that I last saw h[illegible] alive on 4/29 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 4/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04000

151-a

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3118 Lake Ave Cheverly
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alexander Collis McKenzie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Tennie McKenzie
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1879

8. AGE: Years: 66 Months: 6 Days: 24 If less than one day: hrs. min.

9. Birthplace: N.Y. City N.Y.
(Town, county, and state)

10. Usual occupation: Inspector for D.C. Co't.

11. Industry or business

FATHER
12. Name: Alexander McKenzie
13. Birthplace: Scotland

MOTHER
14. Maiden name: Margaret Fraizer
15. Birthplace: Scotland

16. Informant: Collin McKenzie
Address: 3118 Lake Ave Cheverly

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4-23-46 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W.W. Chambers Co
Address: Riverdale, Md

19. 4/22 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner
James J. Boyd M. D. or other
Address: Forestville, Md. Date signed 4-20-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

04005 231

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince George Gen Hospital

How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry Mostyn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mr. Virginia Mostyn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 15, 1867

8. AGE: Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER — 12. Name: Charles Mostyn

FATHER — 13. Birthplace: Eng.

MOTHER — 14. Maiden name: Crolee ?

MOTHER — 15. Birthplace: Eng

16. Informant: Hospital records

Address: Cheverly Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Apr 22, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: F Gaschi sons

Address: Hyattsville Md

19. 4/20 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-17, 1946, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940 to April 17 1946.

and that I last saw h... alive on April 17 1946

Immediate cause of death	DURATION
Acute Coronary Thrombosis.	3 days
Due to	
Due to	
Other conditions: Chronic Bronchitis & Flu	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Klotz M.D.

Address: Hyattsville Md M. D. or other

Date signed: 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-0)

04006

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred: Prince Georges Genral Hospital

How long in hospital or institution? 15m. s

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1251- 45th Place S.E. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Florence Shelley Neilson.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married.

8.(b) Name of husband or wife: Irving I. Neelson

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 23, 1889

8. AGE: Years	Months	Days	If less than one day
56	5	20	hrs. min.

9. Birthplace: Moulden Mass (Town, county, and state)

10. Usual occupation: Dr.

11. Industry or business:

FATHER — 12. Name: William Shelley

FATHER — 13. Birthplace: Mass

MOTHER — 14. Maiden name: Mary J. Sullivan

MOTHER — 15. Birthplace: Chalton, Mass

16. Informant: Mrs. Geraldine Cole

Address: 113 Maryland, Parkland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 23/46 Md. (month) (day) (year)

Cemetery or crematory: Washington Nat'l

Location: Suitland R.Md.

18. Funeral director: W. W. Chamberlain Co.

Address: 5-12-11th St. S. E.

19. 4/21 1946 (Date rec'd by registrar) Amanda Dauney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/20/ 1946, at 3:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Bond M. D. or other

Address: Forestville Md. Date signed: 4-20-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

CERTIFICATE OF DEATH

04007

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Prince Georges Hosp
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)
Street No. Columbia PK.
(If rural, give LOCATION)
2.(a) If veteran, name war: -No-

3. (a) FULL NAME: Noone, Mr. James

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	

8.(b) Name of husband or wife: Mrs. Nell Noone
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): aug. 21 1882

8. AGE:

Years	Months	Days	If less than one day
63	-	-	hrs. min.

9. Birthplace: D.C.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business:
FATHER 12. Name: Robert Noone
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Margaret O'Keefe
15. Birthplace: Washington D.C.
16. Informant: Mr James P. Noone
Address: Landover Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington D.C.
18. Funeral director: F Gaschie Sons
Address: Hyattsville Md
19. 4/25 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-23 1946 at 12 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1946 to April 23 1946 and that I last saw him alive on April 23 1946

Immediate cause of death	DURATION
Generlzd Peritonitis	8 days
Due to: Ruptured Diverticulum	
Due to: Sigmoid Colon	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Resection of Colon & Peritoneum Date of op. April 19, 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Sam Schwartzbard M.D. (M. D. or other)
Address: 1726 Eye or Der. Date signed: 4/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Duplicate

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04008

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH.
County: Prince Georges
City or town: Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life Months
Hospital, Institution, or street address where death occurred:
1015 - 59" Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1015 - 59" Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lewis Edward Norman

3.(b) Social Security Number: 578-18-4597

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of ~~husband or~~ wife: Mary E. Norman
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1901

8. AGE: Years	Months	Days	If less than one day
45	2	28	..... hrs. ..... min.

9. Birthplace: King Georges County, Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Robert Norman
13. Birthplace: King Georges County, Va.

MOTHER
14. Maiden name: Ida Taylor
15. Birthplace: King Georges County, Va.

16. Informant: Ruth Wells (sister)
Address: 1015 - 59" Avenue, Fairmount Hgts.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof: April 7, 1946 (month) (day) (year)
Cemetery or crematory: Salem Baptist
Location: King Georges County Va.

18. Funeral director: Ernest W. Jarvis
Address: 1432 U. N. W. Wash., D. C.

19. 5/3/ 19 46 Carrie Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946 at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1946, to April 2, 1946
and that I last saw him alive on March 30, 1946

	DURATION
Immediate cause of death: Carcinoma of the Esophagus	
Due to: With Generalized Metastasis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward Robinson, M.D.
M. D. or other
Address: 1601 Eastern Ave. N.E. Date signed: 5/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

4009

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days.

Hospital, institution, or street address where death occurred:
Prince Georges General Hospital

How long in hospital or institution? 21 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince Georges.

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5605 - 36th Place.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: O'neill Miss Elizabeth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 17, 1878

8. AGE: Years	Months	Days	If less than one day
68	2	7	— hrs. — min.

9. Birthplace: Wash. DC
(Town, county, and state)

10. Usual occupation: H.W.

11. Industry or business:

FATHER
12. Name: O'Neill Mr. John
13. Birthplace: Ireland

MOTHER
14. Maiden name: Whitney, Miss Georgeanne
15. Birthplace: Md.

16. Informant: Georgianna Winegarter

Address: 3502 - 16th N.E. Wash.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D.C.

18. Funeral director: Albert Clarke

Address: 641 - F St. N.E. Washington D.C.

19. 4/27 (Date rec'd by registrar) 1946 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1946, to April 26 1946 and that I last saw h...er alive on April 26 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	24 hrs.
Due to	
Due to	
Other conditions: Carcinoma of Stomach Hypertension & Uremia (Include pregnancy within 3 months of death)	

Major findings of operation: —

Date of op. 4/6/46 4/18/46

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville Md. Date signed 4-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred: Prince George General Hospital
How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4500 Calvert Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Bess Osborne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	w

6.(b) Name of husband or wife: wm I Osborne
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 12 1873

8. AGE: Years: 72 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Penna Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Shell Reame
13. Birthplace: Pa

MOTHER
14. Maiden name: Emma Bright Full
15. Birthplace: Pa

16. Informant: Mrs Emma Appleman
Address: College Park Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof April 14 1946 (month) (day) (year)
Cemetery or crematory: Mattoon Illinois
Location: Illinois

18. Funeral director: F Gaschi sons
Address: Hyattsville Md.

19. April 14 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-13 1946, at 11 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-15 1945, to 4-13 1946
and that I last saw h.. alive on 4-12 1946

	DURATION
Immediate cause of death: Carcinoma of left breast with metastasis to spinal column	4 years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of left breast Date of op. Nov. 1942

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H Brueggen M.D.
M. D. or other
Address: Mt. Rainier Md Date signed 4-13-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on FILM No. 101 APR 29 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04011

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Years.

Hospital, institution, or street address where death occurred: 4109 - 32nd. St. Mt. Rainier, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4109 - 32nd. St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LELA A. PHILLIPS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Bushrod T. Phillips

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 5, 1875

8. AGE: Years	Months	Days	If less than one day
70 - 71 -			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: James Hughes

13. Birthplace: Va

MOTHER — 14. Maiden name: Lela A. Lewis

15. Birthplace: Va.

16. Informant: John M. Phillips

Address: 3600 - R.I. Ave. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18, 1946 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Alexandria, Va.

16. Funeral director: William J. Malley

Address: 3200 - R.I. Ave. Mt. Rainier, Md.

19. April 17 1946 James Lewey Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1945, to Apr. 16 1946.

and that I last saw h.. alive on April 16 1946.

	DURATION
Immediate cause of death: Carcinomatosis	6 mo.
Due to: Carcinoma of esophagus + Stomach	12 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of esophagus + stomach Date of op. 6/1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Earl M. Graff M. D. or other

Address: 3400 14th St NW Date signed 11/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04012

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale, Maryland (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 9 mos., 24 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 9 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 414- 6th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: Phillip J. Purcell

3. (b) Social Security Number: 229-09-8249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice O. Purcell (dec.)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 6, 1882

8. AGE: Years	Months	Days	If less than one day
64	2	–	..... hrs. ..... min.

9. Birthplace: Augusta, Georgia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: James Purcell
13. Birthplace: Dublin, Ireland

MOTHER — 14. Maiden name: Josephine O'Donnell
15. Birthplace: Dublin, Ireland

18. Informant: Decedent

Address:

17. Removal & burial (Burial, cremation, or removal. Which?) Date thereof Apr. 6, 1946. (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D. C.

18. Funeral director: James P. Regan Inc.

Address: 317 - 7th. Ave. S.E.

19. Apr. 5, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1946, at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1944, to April 5 1946 and that I last saw h.im alive on April 5 1946.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	2 yr 4 mo
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed 4/5/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 04013

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 119 - H. St. S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Albert Reid

3.(b) Social Security Number: 577-22-2809

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6.(b) Name of husband or wife: June Brown Reid

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): January 1, 1921

8. AGE: Years	Months	Days	If less than one day
25	3	24	...hrs. ...min.

9. Birthplace: Thompson, Georgia
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER
12. Name: Eddie Reid
13. Birthplace: Georgia

MOTHER
14. Maiden name: Carrie Bailey
15. Birthplace: Georgia

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Apr. 25, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.

18. Funeral director: John T. Pumphrey & Co.
Address: 1901 - 3rd St. S.E.

19. Apr. 25, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1946 at 5:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1946 to April 25, 1946 and that I last saw him alive on April 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 4/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

04014

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County Prince Georges
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4903 - Decatur street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah E. Rhodes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 27th 1884

8. AGE: Years 61 | Months 9 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace England (Town, county, and state)
10. Usual occupation Housewife & Exec (4 years)
11. Industry or business
FATHER 12. Name Alfred Aspery
13. Birthplace England
MOTHER 14. Maiden name Sarah Elizabeth Doughty
15. Birthplace Birmingham, England
16. Informant James N. Rhodes
Address 4903 - Decatur st Edmonston Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2. 1946. (month) (day) (year)
Cemetery or crematory Flower Hill Cemetery
Location North Bergan N. J.
18. Funeral director H. H. Chambers Co.
Address Riverdale Md.
19. May 1 19 46 James Berry Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 46 at 3.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944. 19 ... to April 30 19 46.
and that I last saw h... alive on April 30/46. 19 ...

	DURATION
Immediate cause of death: Cardiac failure.	
Due to: Myocarditis & Valvular Heart disease.	2yrs.
Due to: —	
Other conditions: Diabetes mellitus & Chronic Intestinal Infection (Include pregnancy within 3 months of death)	12yr.

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph L. Sanders M.D.
M. D. or other
Address 4316 Gallatin St. Date signed April 30/46
Hyattsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

44015

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Mt. Rainier Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Years

Hospital, Institution, or street address where death occurred: 3405 Eastern Ave. Mt Rainier Md.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Ritchie Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ritchie Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Annie Ritchie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 22, 1881

8. AGE:

Years	Months	Days	If less than one day
64	9	5	hrs. min.

9. Birthplace: Ritchie, Pr. Geo. Maryland (Town, county, and state)

10. Usual occupation: Retired Govt. clerk

11. Industry or business: Govt. Printing Office

FATHER

12. Name: John Luit Ritchie

13. Birthplace: Maryland

MOTHER

14. Maiden name: Georgia A. Sweeney

15. Birthplace: Maryland

16. Informant: J. Seth Ritchie

Address: Ritchie, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4 (month) 30 (day) 46 (year)

Cemetery or crematory: Forestville Episcopal

Location: Forestville Md

18. Funeral director: Ritchie Bros

Address: Upper Marlboro Md

19. April 29 (Date rec'd by registrar) 19 46 James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 27 19 46 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 8 19 46, to Apr. 27 19 46

and that I last saw h. alive on Apr. 27 19 46

	DURATION
Immediate cause of death: Cerebral Hemorrhage	15 hrs.
Due to: Hypertension	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm H. Norton M. D. or other

Address: 3827-34th St. Mt Rainier Md Date signed: 4-27-46

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04016

CERTIFICATE OF DEATH

Reg. Dist. No. 289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Pr Ge Co. Contee R.D.
City or town: Contee — Laurel mds
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Md County: Pr Ge
City or town: Laurel Contee Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jesse Early Roebuck. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married.

6.(b) Name of husband or wife: Lucille Roebuck
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 1 1881

8. AGE: Years	Months	Days	If less than one day
65		15	hrs. min.

9. Birthplace: Ga, (Town, county, and state)
10. Usual occupation: minister
11. Industry or business

FATHER
12. Name: Wayne Roebuck.
13. Birthplace: Ga,

MOTHER
14. Maiden name: unknown
15. Birthplace: Ga.

16. Informant: Josephine Rose
Address: R.F.D. 2. box 141 Laurel Md.

17. Burial, cremation, or removal: Removal Date thereof: Apr 16-46
Cemetery or crematory: to Washington D.C.
Location:

18. Funeral director: Shaw Frazier
Address: 389 R.I. Ave N.E. DC

19. Apr 16 1946 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 16 1946, at 7.45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1946, to 4-16 1946 and that I last saw h alive on 4 16 1946

Immediate cause of death	DURATION
Acute Cardiac Dilitation	1 d.
Due to Paralysis	7 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B Akers M. D. or other
Address: Laurel Md. Date signed 4-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

CERTIFICATE OF DEATH

04017

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1383 Bryant St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Ryan, Mrs. Pearl

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Samuel Ryan
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 20, 1871
8. AGE: Years: 74 Months: 8 Days: 7 If less than one day: hrs. min.
9. Birthplace: Richmond, Va. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: ~~Bryant~~ Ryan
13. Birthplace: Richmond Va
MOTHER 14. Maiden name: Unk.
15. Birthplace: Unk.
16. Informant: Harold Ryan (son)
Address: 1383 Bryant St., Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 1946 (month) (day) (year)
Cemetery or crematory: Washington Nat Cemetery
Location: Suitland Maryland
18. Funeral director: J. William Lee's Sons Co.
Address: 366 - 4th St N.E. Wash. D.C.
19. April 27 1946 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-27- 1946 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to April 27 1946 and that I last saw h alive on April 26 1946

	DURATION
Immediate cause of death: Cancer of rectum	2½ yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer of rectum
Date of op. Summer 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert L. McEvoy M.D.
M. D. or other
Address: 40 Main St Laurel Md. Date signed: 4-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

04018

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges.
City or town Cheverly.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges.
City or town Berwyn Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8514 - Edmonston road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Schwartz.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 16. 1871

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Webster N. Y. (Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name Joseph Walke
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany.

16. Informant Fred McCann
Address 8514. Edmonston road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/1946. (month) (day) (year)
Cemetery or crematory Pittsford N. Y. Lawn
Location Pittsford. N. Y.
18. Funeral director A. A. Chambers Co.
Address Riverdale Md.

19. 4/3 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946 at 5.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/31 1946 to 4/2 1946 and that I last saw h[illegible] alive on 4/2 1946

	DURATION
Immediate cause of death Intestinal obs.	5 da
a.	
Due to Fun up. adhesions	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Truman Hoyt M. D. or other
Address Hyatts. Md. Date signed 4/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

04019

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pro Geo County
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: 5311 42 Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hyattsville Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara . Shepherd

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Harry Shepherd
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 4. 1879
8. AGE: Years: 67 Months: Days: If less than one day: hrs. min.
9. Birthplace: Paris Ky (Town, county, and state)
10. Usual occupation: Retired Note teller
11. Industry or business: Pro Geo Bank + Trust Co
FATHER 12. Name: Gray Smith
FATHER 13. Birthplace: Philadelphia Pa
MOTHER 14. Maiden name: Tommie Ann Allen
MOTHER 15. Birthplace: Paris Ky
16. Informant: Edward a Shepherd (son)
Address: 4112 woodberry st Mt Rainier Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11. 1946 (month) (day) (year)
Cemetery or crematory: Forty Lincoln
Location: Washington D.C.
18. Funeral director: E Gaeche Sons
Address: Hyattsville Md
19. April 11 1946 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1946 at 5.10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1946 to April 9 1946 and that I last saw her alive on April 8 1946

	DURATION
Immediate cause of death: Lymphoblastoma	1 year
Due to: Primary site: Not known. Cervix	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hageage M.D. M. D. or other
Address: Mt Rainier, Md. Date signed: April 9 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

04020

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: Pr. Geo. Co.

County 3101 Perry St. Mt Ranier Md

City or town Mt. Ranier, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. Geo. Co.

City or town Mt. Ranier, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3101 Perry St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha L. Slaughter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Lawrence A. Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1866

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace Bristol, Va. (Town, county, and state)

10. Usual occupation Home Maker — retired

11. Industry or business

FATHER 12. Name Wm. Lancaster

13. Birthplace Va.

MOTHER 14. Maiden name Ligon

15. Birthplace Virginia

18. Informant Mrs. Alfred E. Bowers

Address 625 Ray Drive, Silver Spring, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1946 (month) (day) (year)

Cemetery or crematory

Location Fredericksburg, Va.

18. Funeral director The D. H. Ames Co

Address 2901 - 14 St N W D.C.

19. April 29 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28/46 19 ..... at 10 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/12/46 19 ..... to 4/26/46 19 .....

and that I last saw h alive on 4/26/46 19 .....

Immediate cause of death	DURATION
(1) Arteriosclerotic Heart disease	10 years
(2) with Congestive failure	
Due to generalized arteriosclerosis	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John J Sweeney M D M. D. or other

Address 123 8 Mount St NW Date signed 4/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04021

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forrestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Texas County: - - -

City or town: Waxahachie

(If outside city or towo limits, write RURAL and give nearest town)

Street No. 210 Mc Millan

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Duward Franklin Sumner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bennie Sumner (Maiden name of Dorsey) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 14 April 1915

8. AGE: Years	Months	Days	If less than one day
31	0	3	..... hrs. ..... min.

9. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Pilot

11. Industry or business: U. S. Army

FATHER — 12. Name: Deceased

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Official Records

Address: Andrews Field, Washington 20, D. C.

17. Removal (Burial, cremation, or removal, Which?) Date thereof April 17 1946 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

18. Funeral director: Wastler Funeral Home

Address: 301 E. Capitol St. Wash. DC.

19. 4-17-46 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 April 1946 at 11:34 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Extensive third degree burns, multiple fractures and lacerations	
Due to: Aircraft Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please ooderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 17 April 46

Where did injury occur? Prince Georges County (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury: Aircraft Accident Injured at work? Yes

23. SIGNATURE: Deputy medical Examiner James J. I. Forsyth M. D. or other

Address: Forestville Md. Date signed 4-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04022

★ Reg. Dist. No. 2140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Prince George's
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hr hour
Hospital, institution, or street address where death occurred: 6114 Allentown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6114 Allentown Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Arther Swann Jr

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1946

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 30 min.

9. Birthplace: Camp Springs Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Thomas Arthur Swann
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Vera Proctor
15. Birthplace: Maryland

16. Informant: Thomas A. Swann
Address: 6114 Allentown Rd R.F.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1946 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Clinton, Md

18. Funeral director: Thomas Arthur Swann Sr
Address: Camp Springs, Md

19. May 1 1946 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Intra Cranial Hemorrhage	
Due to: Birth injury	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner James D. Ford M. D. or other
Address: Forestville Md Date signed: 4-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

04023

Reg. Dist. No. 272

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

Race track

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eugene E. Sweeney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1869

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Horse trainer

11. Industry or business Racing

FATHER 12. Name John Sweeney

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Hamilton Hall

Address Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 18 46 (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Upper Marlboro Md

18. Funeral director Pitcher Bros

Address Upper Marlboro Md

19. Died 4-16-46 Rec'd 4-16-46 (Date rec'd by registrar) R. Earl Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1946 at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Conductus cular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Lamb M. D. or other

Address Forestville Md Date signed 4-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45a)

CERTIFICATE OF DEATH

★ 04024 Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Geo
City or town Temple Hill Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
5611 Temple Hill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Temple Hill Rd. 5611
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Auburn Tanner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Wid.

6.(b) Name of ~~husband~~ or wife Mary
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5. 1885

8. AGE: Years	Months	Days	If less than one day
60			..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business D.C. Gov.

FATHER
12. Name Tanner
13. Birthplace Va

MOTHER
14. Maiden name Hattie Delta
15. Birthplace Va

16. Informant Leonard Crawford
Address 5611 Temple Hill Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-46 (month) (day) (year)
Cemetery or crematory Culpeper Va
Location
16. Funeral director J. Wm. Lee's Sons
Address 3004 4½ St N.E. Wash. D.C.
19. 4/8 1946 (Date rec'd by registrar) Thos D. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 9:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Apr 7 1946 and that I last saw h~~im~~ alive on April 7 1946
Immediate cause of death Pulmonary Edema — Duration: 1 day
Due to Carcinoma of Lip and R side of face — Duration: 1 yr
Due to
Other conditions none of note
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ~~yes~~ no
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos C Griffith M. D. or ~~other~~
Address Washington 19 D.C. Date signed Apr 8 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

1141134

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:

County Prince George

City or town Beltsville - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George

City or town Beltsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WALTER TAYLOR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	MARRIED

6.(b) Name of husband or wife Georgia

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1879 6.(c) If alive, give age 67 years

8. AGE: Years	Months	Days	If less than one day
67			....hrs. ....min.

9. Birthplace Beltsville Md. (Town, county, and state)

10. Usual occupation Watchman

11. Industry or business

FATHER 12. Name Preston Taylor

13. Birthplace Tennessee

MOTHER 14. Maiden name unknown

15. Informant Georgia Taylor

16. Address Beltsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 46 (month) (day) (year)

Cemetery or crematory Queens Chapel

Location Murkirk Md.

18. Funeral director J. B. Johnson

Address Annapolis

19. April 16 19 46 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 19 46, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 1 1946, to 4 13 1946 and that I last saw him alive on 4 6 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	1 d.
Due to chr. Myocarditis	10 yr.
Due to chr. Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Blanton M. D. or other

Address Laurel Date signed 4-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04033

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince Georges
City or town: Temple Hills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
4931 - Hagan Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Temple Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4931 - Hagan Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter William Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2, 1889

8. AGE:

Years	Months	Days	If less than one day
56	11	20	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: Riggs Bank

FATHER
12. Name: William Henry Taylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Trennel
15. Birthplace: Virginia

16. Informant: Oscar Albert Taylor
Address: 4927 - Hagan Rd, Temple Hills

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington Va

18. Funeral director: Silas F. Messer
Address: 2007 - Nichols Ave. S.E.

19. April 22 1946 (Date rec'd by registrar) Howard J. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Washington D.C. Date signed 4-22-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

04025

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges.
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3900 - Oglethorpe st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LULA COOPER THOMPSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Luther Ernest
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15th 1878

8. AGE: Years	Months	Days	If less than one day
67	11	20	hrs. min.

9. Birthplace Princeton West Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William A Cooper
13. Birthplace Princeton West Va
MOTHER 14. Maiden name Malvina Wyatt
15. Birthplace N. Car.
16. Informant Herbert L. Thompson
Address 51 - Jeavett Drive Cincinnati O
17. Burial Date thereof 4/7/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Monte Vista Cemetery
Location Bluefield West Va
18. Funeral director W. H. Chambers Co.
Address Riverdale Md.
19. April 6th 1946 James Devery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1946, at 2 20 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/26/44 19 to 4/5/46 19
and that I last saw h.. alive on 4/5/46 11 A.M. 19

	DURATION
Immediate cause of death (1) Uremia	3 days
Due to Hypertension and	
Due to Congestive heart failure.	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Sweeney MD
M. D. or other
Address 1238 Underhill St. Date signed 4/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04026

CERTIFICATE OF DEATH

Reg. Dist. No. 142

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fort Washington, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Home

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6980 Livingston Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: VAN NOY, William R.

3.(b) Social Security Number: 718-14-9727

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeanette Van Noy

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Jan 26/96

8. AGE:	Years	Months	Days	If less than one day
	50	2	16	— hrs. — min.

9. Birthplace: Indianapolis, Ind.
(Town, county, and state)

10. Usual occupation: Railroad Yard Conductor

11. Industry or business: Washington, D.C. Terminal

FATHER 12. Name: William R. Van Noy

13. Birthplace: Indianapolis, Ind.

MOTHER 14. Maiden name: Martha Jackson

15. Birthplace: Indianapolis, Ind.

16. Informant: Hospital Records

Address: Fort Washington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/46 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. H. Chambers, Co.

Address: 517 11th St, SE, Washington, D.C.

19. 4/14/46 (Date rec'd by registrar) Irene Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1946 19 at 10:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1946 to April 12 1946 and that I last saw him alive on April 12, 1946

Immediate cause of death	DURATION
Hypertensive heart disease with cardiac enlargement and myocardial insufficiency	about 3 yrs
Due to	
Due to	
Other conditions: Arteriosclerosis, generalized, including retinal	Unk

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. —

Autopsy results: — Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: James A. Smart

James A. Smart, M.C., Chief Med. Officer, M. D. or other

Address: Ft. Washington, Md. Date signed: 4/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

04027

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Tomorrent
Hospital, institution, or street address where death occurred:
Henneche Lunch Room
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riverdale Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Charles L. Warner

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Nellie Warner
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): sept 12, 1873

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: Cincinatti Ohio (Town, county, and state)
10. Usual occupation: machinist - (Retired)
11. Industry or business: U.S. Navy Yard
FATHER 12. Name: Nick Warner
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Ohio
16. Informant: Theodore L. Gardner
Address: 6200 Rogers Park Pl Cincinatti Ohio
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 22-1946 (month) (day) (year)
Cemetery or crematory: Patrick Cemetery
Location: Md
18. Funeral director: L Gascha sons
Address: Hyattsville Md
19. April 22, 19 46 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1946, at 7.20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Ford Deputy medical Examiner M.D. or other
Address: Hyattsville Md Date signed: 4-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

014028

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
501 Belford Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 Belford Place
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: ROSEMARY WELCH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: X
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18th. 1941

8. AGE: Years	Months	Days	If less than one day
4	6	3	hrs. min.

9. Birthplace: Louisville, Ky.
(Town, county, and state)

10. Usual occupation: X

11. Industry or business

FATHER 12. Name: Austin J. Welch, Jr.
13. Birthplace: Cincinatti, Ohio

MOTHER 14. Maiden name: Freida R. Spohr
15. Birthplace: Dridge, Ohio.

16. Informant: Austin J. Welch, Jr.
Address: 501 Belford Pl. Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-24-46 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington, D. C.

18. Funeral director: Wane E Pumphrey
Address: 8434 Ga. Ave. Silver Spring.

19. April 25 1946 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1946 at 12 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-17-1942 to 4-21 1946 and that I last saw h alive on 4-21-1946.

Immediate cause of death	DURATION
(a) Congestive heart failure	5 hours
Due to: pertussis	4 weeks
Due to: Congenital heart disease either patent ductus or septal defect.	4½ years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M E Shoemaker M.D.
M. D. or other
Address: 8605 Woodbury Drive, Silver Spring, Md. Date signed: 4/22/46

04029

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince George's
City or town: College Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Route # 1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: North Carolina County:
City or town: Fort Bragg (If outside city or town limits, write RURAL and give nearest town)
Street No.: 504 Prcht. Inf. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: West, Wallace R
3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 28 February ~~1926~~ 1923 MG.

8. AGE: Years	Months	Days	If less than one day
23	~~10~~ 1	~~19~~ 8	... hrs. ... min.

9. Birthplace: Gate City (county Unk) Alabama (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business:
FATHER 12. Name: West, James N
13. Birthplace: Helenbess, Alabama
MOTHER 14. Maiden name: —
15. Birthplace: —
16. Informant: —
Address: —
17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-7-46 (month) (day) (year)
634 Davis St.
Cemetery or crematory: [illegible, struck through]
Gainesville
Location: Ga.
18. Funeral director: L. Gasch's Sons
ALSO: ~~HOWARD BLIGHT, 4914 Belair rd.~~
Address: Hyattsville Md.
19. April 7 1946 (Date rec'd by registrar) James Sever, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1946, at 1:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death: Hemorrhage and shock
Due to: Crushed chest, Crushed skull
Due to: Crushed abdomen
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 4-6-46
Where did injury occur? College Park P.G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury: Driver of Car in Collision Injured at work? Yes

Deputy medical Examiner
23. SIGNATURE: John T. Boyd M.D. or other
Address: Forestville Md Date signed: 4-7-46

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04030

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 12 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1527 - A. St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME George C. Windle

3.(b) Social Security Number 223-30-1239

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Marguerite S. Windle
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): September 24, 1905

8. AGE: Years	Months	Days	If less than one day
40	6	22	....hrs. ....min.

9. Birthplace: Lantz Mills, Virginia (Town, county, and state)
10. Usual occupation: Government Clerk
11. Industry or business

FATHER
12. Name: William T. Windle
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rose L. Bowers
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Burial, cremation, or removal. Which?: Removal Date thereof: 4/16/46 (month) (day) (year)
Cemetery or crematory: Washington,
Location: D. C.
18. Funeral director: W. W. Chambers Co.
Address: 517-11th st. S.E.

19. (Date rec'd by registrar): apr. 16, 19 46 Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 19 46 at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4, 19 45 to April 16, 19 46
and that I last saw h... alive on April 16, 19 46

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 yr 11 mo
Due to: Tuberculous entero-colitis	2 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 4/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04031

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges County

City or town: Fort Washington, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month

Hospital, Institution, or street address where death occurred:
Veterans Administration Home

How long in hospital or institution? Nineteen (19) days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Unknown County: unknown

City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No. --
(If rural, gives LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

WOODRUM, Hunter H.

3.(b) Social Security Number

705-01-0363

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife: Buelah Floyd

6.(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): June 12, 1889

8. AGE:	Years	Months	Days	If less than one day
	56	9	26	....hrs. ....min.

9. Birthplace: Salisbury, North Carolina
(Town, county, and state)

10. Usual occupation: Brakeman on RR

11. Industry or business: Southern Railroad

FATHER
12. Name: William J. Woodrum
13. Birthplace: Richmond, Va.

MOTHER
14. Maiden name: Mary L. Vaughn
15. Birthplace: Richmond, Va.

16. Informant: Hospital Records, Veterans Administration Home
Address: Fort Washington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 10, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W.W. Chambers Co.

Address: 517-11th St, SE, Washington, D.C.

19. April 10 1946 (Date rec'd by registrar) Irene Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1946 to April 8 1946 and that I last saw h.. im alive on April 8, 1946

	DURATION
Immediate cause of death: Left hemiplegia	12 hrs
Due to: Cerebral embolism	12 hrs
Due to: Arteriosclerotic heart disease with myocardial infarction & myocardial insufficiency	3 wks
Other conditions: Broncho-pneumonia bilateral	1 wk

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. --

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Ingram C. Taylor

INGRAM C. TAYLOR, Capt, MC Acting CMO or other

Address: V.A. Ft. Washington, Md. Date signed: 4/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MAYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

CERTIFICATE OF DEATH

04032

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Prince George's
City or town College Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Route # 1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State North Carolina County
City or town Fort Bragg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 Prcht. Inf.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Wright, Henry

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 17 November 1926
8. AGE: Years 19 Months ~~7~~ 4 Days ~~10~~ 19 If less than one day ... hrs. ... min.
9. Birthplace Booneville (county unk) Indiana
(Town, county, and state)
10. Usual occupation Soldier
11. Industry or business
FATHER 12. Name Wright, Norman A.
13. Birthplace Warrick County, Indiana
MOTHER 14. Maiden name Wright, Ella
15. Birthplace Warrick County, Indiana
16. Informant
Address
17. Removal Date thereof 4-7-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Koehler Funeral Home
Location Boonesville, Indiana
18. Funeral director Gasch's Sons
Address Hyattsville, Md.
Also: HOWARD BRIGHT 4914 Belair Rd.
19. April 7 46 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946, at 1:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...
Immediate cause of death Hemorrhage Shock
Due to Crushed Chest Fractured skull
Due to Crushed left leg
DURATION
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 4-6-46
Where did injury occur? College Park P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Passenger in car in collision Injured at work? yes
Deputy medical Examiner
23. SIGNATURE James I. Boyd M. D. or other
Address Forestville Md Date signed 4-7-46